Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,089.13 for date of service 03/29/01.

   b. The request was received on 03/01/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Request for Medical Dispute Resolution statement on the Table of Disputed Services
   b. HCFA-1450/UB 92
   c. TWCC 62 forms/Medical Audit summary dated 09/12/02
   d. Example EOB(s) from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/07/02
   b. HCFA-1450/UB 92
   c. TWCC 62 form
   d. Carrier Methodology
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier 04/23/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/25/02. The response from the insurance carrier was received in the Division on 05/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services:
"(Carrier) failed to provide any documentation as to how their purported concept of 'fair and reasonable' was derived….(Provider) is requesting a hearing before the Medical Review Division because (Carrier) has improperly reduced or denied payment for services rendered to (claimant)."

2. Respondent: Letter dated 05/07/02:
"It is the (Carrier's) position that a) the requester failed to produce any credible evidence that its billing for the disputed procedures is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) the (Carrier's) payment is consistent with fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same services is below the (Carrier's). Consequently, it is the (Carrier's position that no further reimbursement is due the requester."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/29/01

2. The provider billed a total of $2,486.93 on the date of service in dispute.

3. The carrier reimbursed a total of $397.80; the amount in dispute per the TWCC 60 is $2,089.13. The EOB denial is "M – THE REIMBURSEMENT FOR THE SERVICE BILLED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)." and "M – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM." The medical audit dated 09/12/01 states, "No additional payment is being made …"

4. The carrier's response is timely and no other EOB(s) or re-audits were noted. The Medical Review Division's decision is rendered based on the denial codes submitted to the provider prior to the date this dispute was filed.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011(b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid

by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The carrier has submitted sufficient documentation of it's methodology and, therefore, meets the requirements of Commission Rule 133.304 (i). The carrier indicates that Medicare classifies surgical procedures into 8 groups. All CPT Codes within the same grouping are paid at the same rate (group rate). That reimbursement allowed by Medicare is then multiplied by 20%. This is the co-pay amount under Medicare that the patient pays and which is not allowed by Texas Workers' Compensation Act. The group rate and the co-pay amount are added together to determine the total payment. The carrier notes that regional and geographic differences are taken into account by Medicare. However, the carrier believes that by taking the group rate and adding in the co-pay amount, that its reimbursement is higher than Medicare's rate of reimbursement. Carrier exhibit 2 is a copy of the ASC groups as indicated by the Federal Register, 12/14/93. The carrier has submitted additional information to further support its methodology. Carrier exhibit 3 is a list of CPT codes and the group under which they fall.

The provider has submitted EOB(s) from other carrier showing the percentage rates of the billed amount reimbursed. This list of EOB(s) shows the name of the insurance carrier, the prevailing CPT code, the amount of billed charges, the amount of reimbursement, and the billed payment ratio. The billed payment ration ranges from 68% to 100% with an average of 80%.

Because there are no current fee guideline for ASC(s), the Medical Review Division has to determine what would be fair and reasonable reimbursement. Both parties to the dispute have submitted documentation in support of their position. Regardless of the carrier's application of its methodology, the burden is on the provider to show that the amount of reimbursement requested is fair and reasonable. An analysis of recent decisions of the State Office of Administrative Hearings indicate minimal weight should be given to EOB(s) for documenting fair and reasonable reimbursement. The carrier's documentation is more persuasive and meets the requirement of Sec. 413.011(d) of the Texas Labor Code, "to achieve effective medical cost control." Therefore, no additional reimbursement is recommended

The above Findings and Decision are hereby issued this 18th day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.